MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

APPLICATION FOR APPROVAL AS A NURSING ASSISTANT TRAINING AGENCY

DATE SUBMITTED

☐ NEW APPLICATION ☐ RENEWAL APPLICATION ☐ REVISED APPLICATION

FACILITY/SCHOOL/NAME (PRINT)	TRAINING AGENCY NO.

LIST PREVIOUS FACILITY/SCHOOL NAMES

PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP CODE) PRINT CLEARLY	TELEPHONE

MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE)	FAX NUMBER

ADMINISTRATOR/DIRECTOR (PRINT)

INSTRUCTOR NAME (PRINT)	LICENSE NUMBER

EXAMINER NAME (PRINT)	LICENSE NUMBER

OPERATOR NAME & ADDRESS

PLEASE CHECK THE FOLLOWING IF APPLICABLE:

☐ DHSS LICENSED/FACILITY BASED
- ☐ LICENSED FACILITY - M/M
- ☐ LICENSED FACILITY - NO M/M

☐ DHSS LICENSED/EXTENDED CARE WING OF HOSPITAL

☐ NON-FACILITY BASED
- ☐ VOCATIONAL-TECHNICAL SCHOOL (PUBLIC)
- ☐ VOCATIONAL-TECHNICAL SCHOOL (PRIVATE)
- ☐ JUNIOR COLLEGE
- ☐ COMMUNITY COLLEGE

CERTIFYING AGENCY NAME

What portions of the course will be conducted at the above address: ☐ 75 hours ☐ Clinical ☐ Final exam

What portions of the course **WILL NOT** be conducted at the above address: ☐ 75 hours ☐ Clinical ☐ Final exam

Where will these portions be conducted?

If 75 hours, 100 hours OJT, or examination are conducted anywhere other than at the above address - you must have a signed agreement with the other party. List those training agencies below.

NAME	ADDRESS

NAME(S) OF CLINICAL SUPERVISOR(S) AND LICENSE NUMBERS

ADMINISTRATOR SIGNATURE	DATE

COMMENTS:

RETURN FAX TO HEALTH EDUCATION 573-526-7656

Status letter will be mailed after receipt of application.